



Texas Department of Insurance

Division of Workers' Comp

Medical Fee Dispute Resolution, MS-48
7551 Metro Center Drive, Suite 100 • Austin, Texas 78744-1645
518-804-4000 telephone • 512-804-4811 fax • www.tdi.texas.gov

MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name and Address

MEDICAL CENTER OF PLANO
10030 NORTH MACARTHUR BLVD SUITE 100
IRVING TX 75063

Respondent Name

CITY OF RICHARDSON

Carrier's Austin Representative Box

Box Number 42

MFDR Tracking Number

M4-11-2095-01

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "Non-healing firefighter injury."

Amount in Dispute: \$28,196.20

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "The Requestor is seeking reimbursement from the Carrier for date of service August 14, 2009 in the amount of \$28,196.20 for services rendered." "At the outset it should be noted that the Provider has not timely submitted this MDR Request. Per Rule 133.307(c), 'A requestor shall timely file with the Division's MDR Section or waive the right to MDR.' A timely request 'shall be filed no later than one year after the date(s) of service in dispute.' This request was sent to the DWC on February 15, 2011. The date of service in dispute is August 14, 2009. Therefore, this request was not timely sent for medical dispute resolution."

"Additionally, the Provider performed services that were not preauthorized (or beyond that which was preauthorized). Therefore, payment was properly denied. As evidenced by the attached information, the carrier preauthorized CPT Code 27822, but the Provider did not bill for this preauthorized service. Per Rule 134.600, the carrier is not liable for services that were not preauthorized." "Respondent also maintains that payment was correctly denied for the services provided based on the billing submitted."

Response Submitted by: Harris & Harris, Attorneys At Law, 5900 Southwest Parkway, Building 2, Austin, Texas 78735

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
August 14, 2009 through August 16, 2009	Inpatient Hospital Surgical Services	\$28,196.20	\$0.00

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and all applicable, adopted rules of the Texas Department of Insurance, Division of Workers' Compensation. Texas Labor Code §413.011 (a-d), titled

Reimbursement Policies and Guidelines, and Division Rule at 28 Texas Administrative Code §134.404, titled *Hospital Facility Fee Guideline – Inpatient*, effective for medical services provided in an inpatient acute care hospital on or after March 1, 2008, set out the reimbursement guidelines for hospital inpatient services.

Background

1. 28 Texas Administrative Code §133.307 sets out the procedures for health care providers to pursue a medical fee dispute.
2. The services in dispute were reduced/denied by the respondent with the following reason codes:
Explanation of benefits dated September 15, 2009
 - Precertification/authorization notification absent.
 - Precertification/authorization exceeded.

Issues

1. Did the requestor file for medical fee dispute resolution in accordance with 28 Texas Administrative Code §133.307?
2. Is the requestor eligible for medical fee dispute resolution under 28 Texas Administrative Code §133.307?

Findings

1. 28 Texas Administrative Code §133.307(c)(1) states in pertinent part that a request for medical fee dispute resolution shall be filed no later than one year after the date(s) of service in dispute or waive the right to MDR. The Division shall deem a request to be filed on the date the MDR Section receives the request. The dates of service in dispute are August 14, 2009 through August 16, 2009. The request for medical dispute resolution was received in the Medical Fee Dispute Resolution (MFDR) section on February 15, 2011.
2. The Division finds no documentation to support that the dispute was filed timely. Therefore, the requestor has waived the right to medical fee dispute resolution.

Conclusion

For the reasons stated above, the division finds that the requestor has established that no reimbursement is due. As a result, the amount ordered is \$0.00.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code §413.031, the Division has determined that the requestor is entitled to \$0.00 reimbursement for the disputed services.

Authorized Signature

_____ Signature	_____ Medical Fee Dispute Resolution Officer	_____ September 8, 2011 Date
_____ Signature	_____ Medical Fee Dispute Resolution Manager	_____ September 8, 2011 Date

YOUR RIGHT TO REQUEST AN APPEAL

Either party to this medical fee dispute has a right to request an appeal. A request for hearing must be in writing and it must be received by the DWC Chief Clerk of Proceedings within **twenty** days of your receipt of this decision. A request for hearing should be sent to: Chief Clerk of Proceedings, Texas Department of Insurance, Division of Workers Compensation, P.O. Box 17787, Austin, Texas, 78744. **Please include a copy of the Medical Fee Dispute Resolution Findings and Decision** together with other required information specified in Division rule at 28 Texas Administrative Code §148.3(c).

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.